Effective Date:_____

PAYROLL DEDUCTION FORM
(Per Bi-Weekly Payroll)

PLEASE SIGN BACK OF FORM

PRINT NAME: _____ Last 4 digits of social security # _____

I am electing the following medical coverage:

- ☐ BLUE CROSS BUY-UP Single coverage $31.27 per pay period ($62.54 per month)
- ☐ BLUE CROSS BUY-UP Family coverage $291.46 per pay period ($582.92 per month)
- ☐ BLUE CROSS BASE Single coverage $10 per pay period (City pays $482.16 per month)
- ☐ BLUE CROSS BASE Family coverage $227.29 per pay period ($454.58 per month)
- ☐ BLUE CROSS HDHP Single coverage $0 per pay period (City pays $28.52 per month to H.S.A.)
- ☐ BLUE CROSS HDHP Family coverage $191.54 per pay period ($383.08 per month City paid)
- ☐ WAIVER OF MEDICAL COVERAGE (Proof of other group coverage required)
- ☐ WELLNESS PROGRAM Level 1 Participant ($5.00 credit per pay period)
- ☐ WELLNESS PROGRAM Level 2 Participant ($10.00 credit per pay period)

I am electing the following VOYA Deferred Compensation Plan coverage:

- ☐ City contribution to VOYA of $30 per pay period
- ☐ VOYA pre-tax deferral of _____or $_____ (not to exceed $18,000 total combined)
- ☐ VOYA pre-tax age 50 catch-up provision $_____ per pay period (not to exceed $24,000 total combined)
- ☐ ROTH 457 after tax $_____ per pay period (not to exceed 18,000 total combined)
- ☐ ROTH 457 after tax age 50 catch-up provision $_____per pay period (not to exceed 24,000 total combined)
- ☐ Waive the VOYA Deferred Compensation Plan coverage

I am electing the following ICMA Deferred Compensation Plan coverage:

- ☐ City contribution to ICMA of $30 per pay period
- ☐ ICMA deferral of _____% or $_____ (not to exceed $18,000 total)
- ☐ ICMA Age 50 catch-up provision $_____ per pay period (not to exceed $24,000 total)
- ☐ ROTH 457 After Tax $_____ per pay period (not to exceed 18,000 total combined)
- ☐ ROTH 457 After Tax Age 50 catch-up $_____ per pay period (not to exceed 24,000 total combined)
- ☐ Waive the ICMA Deferred Compensation Plan coverage

I am electing the following Health Savings Account coverage:

- ☐ HEALTH SAVING ACCOUNT (H.S.A.) $_____ contributed per pay period ($3,350/$6,750)
- ☐ HEALTH SAVING ACCOUNT age 55 catch-up $_____ contributed per pay period ($4,350/$7,750)
- ☐ Waive the HEALTH SAVINGS ACCOUNT

I have elected to participate in the Blue Cross Blue Shield HDHP medical plan and want the EMPLOYER monthly contribution of $28.52 to go into the following account: (FSA Limited – Max ER Contribution $500 per year)

- ☐ HEALTH SAVINGS ACCOUNT (H.S.A.) $14.26 deposited per pay period ($28.52 per month City paid)
- ☐ FLEXIBLE SPENDING LIMITED ACCOUNT (F.S.A.) $14.26 deposited per pay period ($28.52 per month City paid)

I am electing the following Dental coverage:

- ☐ DELTA DENTAL Single Coverage $0 per pay period ($32.44 per month, City paid)
- ☐ DELTA DENTAL Family Coverage $27.65 per pay period ($55.30 per month)

I am electing the following Vision coverage:

- ☐ VSP EXAM ONLY Single Coverage $0 per pay period ($0 per month)
- ☐ VSP EXAM ONLY Family Coverage $0 per pay period ($0 per month)
- ☐ VSP BUY UP Single Coverage $2.89 per pay period ($5.78 per month)
- ☐ VSP BUY UP Family Coverage $7.31 per pay period ($14.62 per month)

I am electing the following Voluntary Term Life coverage:

- ☐ VOLUNTARY TERM LIFE Employee coverage for $_____ and the cost is $_____ per pay period
- ☐ Employee Date of Birth_____ Spouse Date of Birth_____
- ☐ VOLUNTARY TERM LIFE Spouse coverage for $_____ and the cost is $_____ per pay period
- ☐ VOLUNTARY TERM LIFE Child(ren) coverage for $_____ and the cost is $_____ per pay period

  Number of Children:_____ Child Date of Birth:_____

  Child Date of Birth:_____ Child Date of Birth:_____

  Child Date of Birth:_____ Child Date of Birth:_____

  Child Date of Birth:_____ Child Date of Birth:_____
- ☐ Waive the VOLUNTARY TERM LIFE

I am electing the following Flexible Spending Account (FSA) coverage: <u>24 PAY PERIODS</u>

- ☐ FLEXIBLE SPENDING ACCOUNT for Medical $_____ contributed per pay period ($2550 max)
- ☐ FLEXIBLE SPENDING ACCOUNT for Dependent Care $_____ contributed per pay period ($5000 max)
- ☐ LIMITED FSA for Dental and Vision ONLY $_____ contributed per pay period ($2550 max)
- ☐ Waive the FLEXIBLE SPENDING ACCOUNT

I am electing the following Short Term/Long Term Disability Benefit coverage: Date of Birth_____

- ☐ SHORT TERM DISABILITY Weekly Amount _____ $_____ contributed per pay period
- ☐ LONG TERM DISABILITY Monthly Amount _____ $_____ contributed per pay period
- ☐ Waive the Disability benefit

I authorize the City of Flagstaff to withhold/deduct through payroll deductions, the amounts elected for my group Medical, Dental, Vision, Voluntary Term Life, Flexible Spending Account, Voluntary Short Term/Long Term Disability and the ASRS Defined Contribution Plan. These elections cannot be changed until the next open enrollment period unless I experience a life changing event such as divorce, marriage, birth or adoption of a child, change in hours/ job by me or my spouse/domestic partner. Deductions for the Deferred Comp Account & the Health Savings Account may be changed without a life changing event.

_____ _____

Employee Signature Date

☐ **ARIZONA STATE RETIREMENT** ☐ **PUBLIC SAFETY RETIREMENT**

HR Use Only

Life Changing Event: _____